

This ACR RADPEER™ Participation Agreement must be signed by the Group Chair/Medical Director (Administrator) of the Department or Group. Original, electronic or faxed signatures are required on this form. Stamped signatures are not acceptable.



1891 Preston White Drive
Reston, Virginia 20191

RADPEER™ APPLICATION

NEW RENEWAL RADPEER Group # _____

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____

Individual practice locations

This option is only for groups that wish to have peer review data separated by location.

Group Radiology Chair /Medical Director (Administrator):

Point of Contact (POC):

Phone: _____ Fax: _____

E-Mail: _____

Number of Physicians in Group: _____

ACR RADPEER™

Please check all that apply:

Academic Institution	
Hospital	
Free Standing Office	
Government/VA	

Please Complete:

Type/per year	Number
Radiography/year	
Ultrasound exams/year	
CT scans/year	
MRI scans/year	
Mammograms/year	
Nuclear Medicine scans/year	
PET	
Interventional procedures/year	

Please check one:

# Physicians	Annual Fee	
2-5	\$800	
6-15	\$1500	
16-25	\$2200	
26-35	\$3000	
36-45	\$3800	
46-55	\$4600	
56-65	\$5400	
66-75	\$6200	
76-85	\$7000	

Check enclosed, made payable to ACR (Include RADPEER™ # on check, if available)

OR

Charge credit card VISA MasterCard American Express

Card No. _____ Exp. Date _____

Name of Cardholder: _____

Signature: _____

Please enroll

(name of group)

in the ACR RADPEER™ program. I agree to submit the amount of

\$ _____ for one year participation in the RADPEER™ program.

Term of participation will begin on date your application is processed and will extend to the last calendar day of the twelfth month following this date.

Print Name

Signature

Date

Group Chair/Medical Director

I understand that all information received from my group under the RADPEER™ program will be treated as privileged and confidential peer review and maintained in strictest confidence.

Please return the RADPEER™ application and fee to:

**RADPEER™
ATTN: Fern Jackson
1891 Preston White Drive
Reston, VA 20191
Phone: 703-715-3490 Fax: 703-390-9837
email: fjackson@acr.org**

**** Make check payable to The American College of Radiology.**

For ACR office use only

Executed on _____, 20_____

Expiration Date _____

ACR RADPEER™, Program Manager